WEST VIRGINIA CODE: §61-12A-2

§61-12A-2. Responsibilities of the Fatality and Mortality Review Team and advisory panels

(a) The Fatality and Mortality Review Team shall establish the following advisory panels to carry out the purposes of this article, including:

(1) An unintentional pharmaceutical drug overdose fatality review panel to examine, analyze, and review deaths resulting from unintentional prescription or pharmaceutical drug overdose;

(2) A child fatality review panel to examine, analyze, and review deaths of children under the age of 18 years;

(3) A domestic violence fatality review panel to examine, analyze, and review deaths resulting from suspected domestic violence; and

(4) An infant and maternal mortality review panel to examine, analyze, and review the deaths of infants and women who die during pregnancy, at the time of birth, or within one year of the birth of a child.

(b) The members of the Fatality and Mortality Review Team shall serve as members of each of the advisory panels established pursuant to this article.

(c) The Commissioner of the Bureau for Public Health, in consultation with the Fatality and Mortality Review Team, shall propose rules for legislative approval in accordance with §29A-3-1 *et seq*. of this code that the advisory panels shall follow. Those rules shall include, at a minimum:

(1) The representatives that shall be included on each advisory panel;

(2) The responsibilities of each of the advisory panels, including but not limited to, each advisory panel's responsibility to:

(A) Review and analyze all deaths as required by this article;

(B) Ascertain and document the trends, patterns, and risk factors; and

(C) Provide statistical information and analysis regarding the causes of certain fatalities;

(3) The standard procedures for the conduct of the advisory panels;

(4) The processes and protocols for the review and analysis of fatalities and mortalities of those who were not suffering from mortal diseases shortly before death;

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(5) The processes and protocols to ensure confidentiality of records obtained by the advisory panel;

(6) That the advisory panels must submit a report to the Fatality and Mortality Review Team annually, the date the annual report must be submitted, and the contents of the annual report;

(7) That the advisory panel may include any additional persons with expertise or knowledge in a particular field that it determines are needed in the review and consideration of a particular case as a result of a death in §61-12A-1(a) of this code;

(8) That the advisory panel may provide training for state agencies and local multidisciplinary teams on the matters examined, reviewed, and analyzed by the advisory panel;

(9) The advisory panel's responsibility to promote public awareness on the matters examined, reviewed, and analyzed by the advisory panel;

(10) Actions the advisory panel may not take or engage in, including:

(A) Call witnesses or take testimony from individuals involved in the investigation of a fatality;

(B) Contact a family member of the deceased;

(C) Enforce any public health standard or criminal law or otherwise participate in any legal proceeding; or

(D) Otherwise take any action which, in the determination of a prosecuting attorney or his or her assistants, impairs the ability of the prosecuting attorney, his or her assistants or any law-enforcement officer to perform his or her statutory duties; and

(11) Other rules as may be deemed necessary to effectuate the purposes of this article.

(d) The Fatality and Mortality Review Team shall submit an annual report to the Governor and to the Legislative Oversight Commission on Health and Human Resources Accountability concerning its activities within the state and the activities of the advisory panels. The report is due annually on December 1. The report is to include statistical information concerning cases reviewed during the year, trends and patterns concerning these cases and the team's recommendations to reduce the number of fatalities and mortalities that occur in the state.

(e) The Fatality and Mortality Review Team may provide reporting to birth facilities to inform internal peer review activities. Such information shall be deemed confidential and shall be used only for peer review purposes.

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